

# **Medicaid Benchmark (Alternate Benefit) Plan and Cost Sharing**

*Legal Requirements and State Considerations for Coverage of New Adults*

---

**Washington Health Care Authority**  
**December 2012**

**WORKING DRAFT**

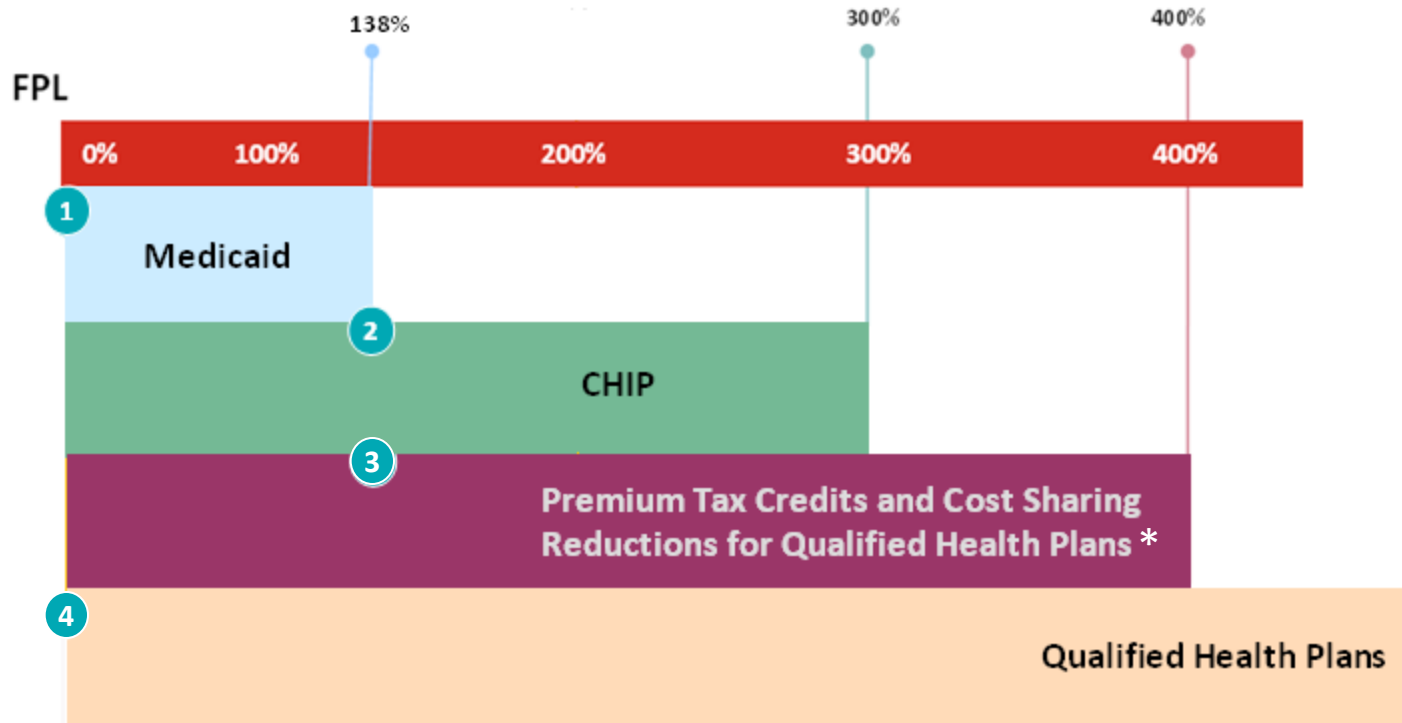
**manatt**

---

## **Legal Requirements for Designing Washington's Benchmark Benefit (Alternate Benefit) Plan**

---

# Coverage Continuum in 2014



\* Federal Basic Health Plan Option for individuals with incomes between 138% and 200% of the FPL will not be available in 2014.

# Streamlined Coverage Options in 2014

Medicaid Standard
CHIP
HC for Workers with Disabilities
Family Planning Extension
Take Charge Family Planning
Psych. Indigent Inpatient Program
Involuntary Treatment Act
Kidney Disease Program
ADATSA
Basic Health Plan
Medical Care Services Program
SSI Presumptive (Old GA-X)



Medicaid Standard
Medicaid Benchmark
CHIP
QHP (with subsidies)
QHP (without subsidies)

# Benchmark Terms of Art/Terms of Confusion

- Essential Health Benefits
- Essential Health Benefits Reference Plan
- Benchmark
- Base Benchmark Plan
- Alternative Benefit Plans

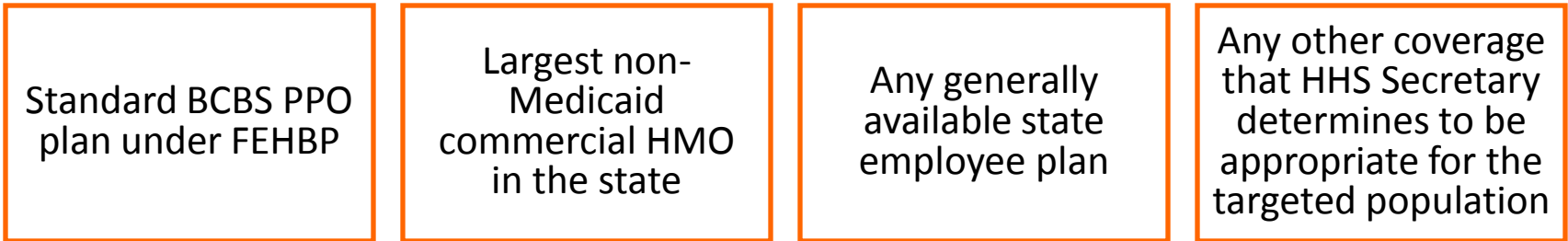
# New Adult Eligibility Group Receives Benchmark Coverage

ACA establishes new, mandatory Medicaid eligibility group of non-pregnant adults between 19-65 with incomes  $\leq 133\%$  FPL

- This “new adult eligibility group” consists of childless adults, and parents/caretakers above  $\sim 40\%$  FPL
- States must provide Benchmark or Benchmark-equivalent coverage described under §1937 of the Social Security Act (DRA), as modified by the ACA to adults in new adult eligibility group
- States will receive enhanced FMAP for “newly eligibles” within new adult eligibility group

# Benchmark Coverage Under the Deficit Reduction Act

- Benchmark coverage linked to:



**Benchmark Reference Plan:**  
Amount, duration and scope limits apply; Cost-sharing requirements do not.

- Benchmark must cover:
  - EPSDT for any child under age 21 covered under the state plan
  - FQHC/RHC services
  - Non-emergency transportation
  - Family planning services and supplies
- State may supplement benefits in Benchmark reference plan

# Certain Populations are Benchmark Exempt

## These Population Groups are Entitled to Standard Benefits

- Pregnant women
- Individuals who qualify for Medicaid based on being blind or disabled
- Dual eligibles
- Terminally ill hospice patients
- Inpatients in hospitals, nursing home and ICF who must spend all but a minimal amount of their income for the cost of medical care
- TANF/Section 1931 parents and caretakers
- Medically frail individuals, including those with disabilities that impair ability in one or more activities of daily living
- Children in foster care
- Individuals who qualify for LTC services based on their medical condition
- Individuals who only qualify for emergency care
- Individuals who qualify based on spend down

# Benchmark Must Cover Essential Health Benefits

Beginning in 2014, Benchmark must include all Essential Health Benefits (EHBs) for:

- new adult eligibility group (newly-eligible and currently-eligible)
- all existing Benchmark populations

## **EHB Categories:**

- Ambulatory services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

## EHBs and Medicaid Benchmark Coverage (cont'd)

- EHB reference plan for Medicaid may be different than EHB reference plan for individual and small group.
- State must select one of ten EHB reference plans.
- State may select its full Medicaid package as its Benchmark coverage under “Secretary-approved” option but must also select an EHB reference plan.
- State must specify EHB reference plan as part of 2014-related Medicaid State Plan changes.
- States must provide public notice and reasonable opportunity to comment ***before*** submitting Benchmark plans to CMS.

### **Unlike in individual and small-group market:**

- State may have more than one Benchmark for new adult group
- No default reference plan – State must choose

## As of 2014, Mental Health Parity Applies to Benchmark

- Under current law, federal mental health parity (FMHP) requirements only apply to Medicaid managed care, not Medicaid fee-for-service.
- The ACA expands some FMHP requirements to all Benchmark and Benchmark equivalent plans
  - Mental health and substance abuse benefits must have parity with medical/surgical benefits with respect to:
    - Financial requirements (deductibles, co-pays, and coinsurance)
    - Treatment limitations (frequency/scope/duration)
  - Because Benchmark must cover EPSDT, it meets FMHP requirements for individuals under 21

## State Medicaid Director (SMD) Letter Released on 11/20/12

- Medicaid benchmark benefits to be referred to as “Alternate Benefit Plans.”
- Initial Alternate Benefit Plans will be in effect for two years through December 31, 2015.
- SPA describing Alternate Benefit Plans may be submitted starting in the first quarter of 2013 for January 1, 2014 effective date.
- If State intends to implement Alternate Benefit Plan through managed care delivery system, amended managed care contract must be submitted to CMCS.

## Alternate Benefit Plan Open Questions

- Is Washington required to include benefits covered in the selected EHB reference plan that are not covered in State's Standard Medicaid, e.g., chiropractic services or naturopathy?
- Must the State include in the Alternate Benefit Plan all services or providers in the selected reference plan including those that federal Medicaid does not cover, e.g., institutes of mental disease or fertility treatment?
- May the State include waiver services in its Alternate Benefit Plan?

# Considerations for Designing Washington's Alternate Benefit Plan

# Different Categories Eligible for Different Benefit Packages

Medicaid Category	Standard Medicaid	Alternate Benefit Plan
Children	✓	
Pregnant Women	✓	
Low Income Families (LIF)	✓	
Aged, Blind, Disabled	✓	
Section VIII Adults		✓ (unless Benchmark exemptions apply to sub-population)

# Washington must Select EHB Reference Plan

## EHB Reference Plan Options:

- Small group plans (3 choices): largest plan by enrollment in any of the three largest small group insurance products
- State employee plans (3 choices): three largest state employee plans by enrollment
- Federal employee plans (3 choices): three largest federal employee plans by national enrollment
- HMO (1 choice): largest commercial HMO in state (non-Medicaid)

# Medicaid Standard and EHB Reference Plan Comparative Analysis

- Select EHB Reference Plan from one of 10 options.
- Determine if selected EHB reference plan includes required 10 statutory categories.
- Compare benefits across selected EHB Reference Plan and Medicaid Standard.
- Identify meaningful differences in coverage.
- Note where State may be required to include EHB-covered service in Alternate Benefit Plan and differences with Medicaid Standard.
- Conduct mental health parity analysis:
  - Cross-walk mental health and substance abuse services from EHB Reference plan to Alternate Benefit Plan
  - Apply Mental Health Parity

# Additional Considerations in Alternate Benefit Plan Design for New Section VIII Adult Eligibility Group

- Clinical needs of new adult population
- Alignment across Medicaid categories
- Alignment between Medicaid and QHP
- Administrative ease for beneficiary and State
- Whether and how to apply cost-sharing
- FMAP implications:
  - State receives enhanced match for newly eligibles
  - Populations in new adult eligibility group who would have been eligible for comprehensive benefits under another eligibility category as of Dec. 1, 2009 are not “newly-eligible”

# Options in Designing Alternate Benefit Plan

- Align Alternate Benefit Plan to Medicaid Standard:
  - Add Alternate Benefit Plan benefits to Medicaid Standard
  - Add Medicaid Standard benefits to Alternate Benefit Plan
- Offer different benefit packages to different groups:
  - Alternate Benefit Plan to new adult group
  - Medicaid Standard to children, pregnant women, LIF parents and ABD

# Legal Requirements for Designing Medicaid Cost-Sharing

# States Have Cost Sharing Flexibility Under Current Law

Sections 1916 & 1916A of the Social Security Act (as added by the Deficit Reduction Act of 2005 (“DRA”)) describe permissible cost sharing. The ACA does not change Medicaid cost sharing rules.

- Cost sharing guidelines vary according to enrollee eligibility category, income level, and type of service provided
- Certain cost sharing requirements can be implemented through State Plans (co-payments, deductible, or similar charges, for most services)
- States may be able to apply cost sharing beyond the parameters of 1916 and 1916A, including co-premiums and co-payments exceeding nominal amounts, through a demonstration waiver
- Additional federal cost sharing guidance expected shortly

# Cost Sharing Parameters Under State Plan Authority

Maximum allowable Medicaid Premiums and Cost sharing		
	≤ 100% FPL	≤ 150% FPL
Aggregate cap	5% family income	5% family income
Premiums	Not allowed	Not allowed
Maximum service-related co-pays/co-insurance		
Most services	Nominal \$3.80 (2012)	10% of cost
Non-emergency ER <sup>1</sup>	Nominal \$3.80 (2012)	2x nominal \$7.60
Rx Drugs	Nominal \$3.80 (2012)	Nominal \$3.80
Institutional	Less than or equal to 50% of cost for 1 <sup>st</sup> day of institutional care	10% of cost
MCO co pay	Nominal \$3.80 (2012)	10%
Deductible	Nominal \$2.55 (2012)	10% of cost

# Individuals and Services Exempt From Cost Sharing

- Services to pregnant women (related to pregnancy or a medical condition that might complicate pregnancy; smoking cessation)
- Services to terminally ill beneficiaries receiving hospice
- Services to inpatients required to spend most of their income for medical care costs
- Emergency services
- Family planning services and supplies
- Items furnished to an Indian directly by an Indian health care provider or referral
- Each service may only be subject to one type of cost sharing

## Cost Sharing Rules for Non-Emergency Services in the ER

- Cost sharing for individuals below 100% FPL is limited to the nominal amount: \$3.80 for FY 2012
- Cost sharing for individuals between 100% and 150% FPL can be up to two times the nominal amount, or \$7.60 in FY 2012
- Hospital must first determine that enrollee does not have an emergency medical condition
- Prior to receiving non-emergency services, the hospital must:
  - Notify the enrollee that payment is required before the service can be provided;
  - Provide the name and location of alternate available provider and that the alternate provider can provide the service without cost sharing;
  - Provide a referral to coordinate scheduling.

# Cost Sharing Rules for Prescription Drugs

- States may implement a tiered drug formulary with cost-effective drugs within specific drug classes designated as “preferred”
- Cost sharing may be waived or reduced for preferred drugs within a class, or cost sharing can be applied to “non-preferred” drugs within the class
- Cost sharing is limited to nominal amounts regardless of family income -- \$3.80 for FY 2012
- For exempt populations, cost sharing is not permitted on preferred drugs, but can be applied for non preferred drugs

# Aggregate Cost Sharing Limit

- Total aggregate amount of cost sharing imposed for all individuals in a family with incomes between 100 and 150% FPL may not exceed 5% of the family income.
  - Applied on a quarterly or monthly basis.
  - Each state may define the method for determining family income for purposes of cost sharing calculations.
- States are required to track an individual's cost sharing contributions in order to determine when the 5% aggregate maximum is reached.

# Waiver of Federal Cost Sharing Rules Under Section 1115

- Under Section 1916 and 1916a, cost sharing limits may be waived for expansion or demonstration populations covered under Section 1115 Waiver.
- Under Section 1115 Waiver authority, for expansion or demonstration populations, states have imposed co-payments above permitted levels and co-premiums below 150% FPL.

# Cost Sharing Waiver Authority for Mandatory and Optional Populations

- In order to waive co-payments with respect to optional and mandatory categories, it appears a state must meet both Section 1115 and Section 1916(f) requirements:
  - test a unique and previously untested use of copayments
  - be limited to a period of not more than 2 years
  - provide benefits to the recipients reasonably expected to be equivalent to the risks to the recipients
  - be based on a reasonable hypothesis which the demonstration is designed to test in a methodologically sound manner, including the use of control groups of similar recipients of medical assistance in the area
  - be voluntary, or make provision for assumption of liability for preventable damage to the health of recipients of medical assistance resulting from involuntary participation

# Considerations for Designing Medicaid Cost Sharing

# Overview of States' Implementation of Cost Sharing for Adults

## ■ **Co-payments:**

- 40 states require co-payments for select services from LIF parents enrolled in Medicaid.
- 26 states require co-payments from adults in their Section 1115 Waiver or state-funded expansion programs.

## ■ **Co-Premiums and enrollment fees:**

- Two states (IL and WI) charge co-premiums to LIF parents with incomes at or greater than 150% FPL.
- 21 Section 1115 Waiver or state-funded expansion programs apply co-premiums.

Source: Heberlein, M. et. al., for the Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, "Performing under Pressure: Annual Findings of a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in Medicaid and CHIP, 2011-2012." January 2012.

# Washington's Cost Sharing Policy Principles

Medicaid expansion offers new opportunities to reconsider enforceable, limited, cost sharing for the new adult group to:

- Promote use of evidence-based cost-effective treatment while reducing low-value and medically unnecessary care;
- Avoid discouraging or creating barriers to essential and appropriate care;
- Avoid cost-sharing cliff between Exchange and Medicaid coverage;
- Maintain consistency with historical policy direction for low-income adults to contribute to their health care;
- Facilitate provider collection of required co-payments;
- Maximize use of consumer-friendly, administratively simple processes.

# Washington's Experience With Implementing Cost Sharing

- **Basic Health Plan** (income between 0-200% of FPL):
  - Premiums and cost sharing for all enrollees:
    - Premiums: based on age/income - start at \$17/month
    - Co-Payments:
      - \$15 co-payment for non-preventive office visit
      - \$100 co-payment for non-emergent ER visit
    - Co-insurance/deductibles:
      - \$250 standard deductible per person, then
      - 20% co-insurance for most services up to \$1,500 annual out-of-pocket limit
  - Wait list of over 170,000 people indicates strong demand for program
  - No evidence that point-of-service cost-sharing served as a barrier for people accessing coverage.
- **Children's Health Insurance Program (CHIP)** (income between 200-300% FPL):
  - Premiums of \$20 or \$30 per child
  - No point-of-service cost sharing
- **Categorically Needy Medicaid** for children and adults:
  - No cost sharing or premium requirements

## Cost Sharing “Straw Model” for Review

- Limited, enforceable cost sharing for newly eligible adults between 100-138% of the FPL as a bridge to Qualified Health Plan coverage in the Exchange
- Preliminary 2014 implementation design
  - No premiums
  - No cost-sharing in Medicaid fee for service
  - Cost sharing through managed care plans only
  - Out of pocket costs tracked by managed care plans
- Align point of service cost sharing for Medicaid adults with Exchange adults at same income level

# Thank You!

**Deborah Bachrach**

[dbachrach@manatt.com](mailto:dbachrach@manatt.com)

(212) 790-4594

**Kinda Serafi**

[kserafi@manatt.com](mailto:kserafi@manatt.com)

(212) 790-4625